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WILLIAM T FUJIOKA
Chief Executive Officer

January 31, 2011

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: William T Fujioka
Chief Executive Officer

STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE (ITEM NO. S-1, AGENDA OF FEBRUARY 1, 2011)

Item No. S-1 on your Board's February 1, 2011 Agenda, is the Health Department Budget Committee of the Whole and report on the status of the 1115 Medicaid Waiver (Waiver). This memorandum provides supplemental information regarding the Department of Health Services' (DHS) efforts for the Waiver implementation since the report by DHS dated November 30, 2010.

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of DHS, and the Directors of the Departments of Mental Health (DMH) and Public Health to report back to the Board within 30 days, and monthly thereafter, on a proposed plan to implement the Waiver. The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health, and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives.

Prior to reaching out to these noted associations, the departments needed further information to assess and formulate an overall framework for integrating health, mental health, and substance abuse programs. Although there was a need to focus on internal policy and strategy matters, the departments will reach out to the noted associations and are targeting a meeting for the week of February 7. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010. Many details of this Waiver are still being addressed, including the allocation of funding to individual counties across the State.

Implementation of the Waiver is a major County undertaking and although details have not been finalized, DHS and DMH are diligently working on 12 critical elements/plans of this important initiative. A summary and status for each of the 12 components is described in the Attachment. Our next status report to your Board is targeted for March 1, 2011.

If you have any questions, please contact me or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160.

WTF:SAS
MLM:gl

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Public Health

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS will build upon its existing Healthy Way LA (HWLA) program, which currently has 52,000 active members. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. The DHS Ambulatory Care Team is reviewing the required scope of services and access standards to develop an implementation plan for the MCE DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has released a LIHP application and instructions, with a due date of February 14, 2011. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. DMH staff will be trained on eligibility requirements and enrollment procedures; a "train the trainer" session has been scheduled for February 10, 2011. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment.

Waiver Element/Plan	Status
	DHS, DMH and DPH have held several joint meetings to discuss the inclusion of mental health and limited substance abuse benefits in the LIHP. DPH has decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Discussions with the PPPs are underway to determine the payment methodology. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS has initiated negotiations with three hospitals for services in areas of the County that are not served by a County hospital. If negotiations are not successful, the County must provide transportation to County hospitals for patients residing in those areas. Discussions have begun with Antelope Valley Hospital, University of California Los Angeles, and a private hospital in the east San Gabriel Valley. Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the

Waiver Element/Plan	Status
	LIHP, DHS and PPPs are discussing alternative payment methodologies that may be permitted under the Waiver.
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	The California Association of Public Hospitals (CAPH) is still working with Centers for Medicare and Medicaid Service (CMS) and the State to finalize a framework for submission of the milestones. DHS is developing its milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. Since discussions with CMS are not complete, the target date by which plans must be finalized and submitted to the State is tentatively set for February 8, 2011, with expected CMS approval by April 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. As part of the development of the DSRIP plan for the County, DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to develop proposals for worker training for consideration within the DSRIP.

Waiver Element/Plan	Status
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State expects to begin mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. As reported to your Board in the December 22, 2010 "Status Report on Negotiations with LA Care and the Department of Health Services Ambulatory Care Restructuring," the CEO and DHS will complete negotiations and present to your Board by March 1, 2011, a provider agreement between L.A. Care and County facilities for conversion of SPDs into managed care.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. Examples of specific action steps currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is scheduled for staff in the pilot medical home clinics.
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) are meeting and will be evaluating the technical assistance needs once an initial framework is developed [refer to item #11].
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (68,000 total, with approximately 52,000 active members with services in the last year) will be grandfathered into the new MCE program. The State released its Low Income Health Program letter of intent (which was submitted on January 24, 2011) and application, which is due February 14, 2011. Negotiations with LA Care are underway regarding expectations for

Waiver Element/Plan	Status
	the SPD enrollment into managed care. The key objective of the County is retaining the approximately 27,600 patients who use DHS for their care and another 2,700 who receive primary care from the PPPs and obtain specialty and inpatient care at DHS.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	DHS is developing a Waiver oversight staffing plan for CEO review targeted for February that will ensure the implementation, monitoring and reporting on Waiver milestones and programs.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	Once the framework for the DSRIP is completed, DHS will develop a plan with timeline for infrastructure investments needed to achieve implementation of all aspects of the Waiver.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	DHS has begun meeting with DMH and DPH to discuss the inclusion of mental health and limited substance abuse benefits in the LIHP. Senior leadership from the three departments are developing a work plan that includes analysis of relevant data, development of enrollment and referral processes, plans for meeting access requirements, development of care coordination and information sharing protocols, and the establishment of integrated medical homes. An integrated primary care/mental health prevention and early intervention (PEI) program at El Monte Comprehensive Health Center was implemented in December, 2010. Mental health staff are now co-located within the facility and are available to conduct PEI services for HWLA members and other patients as capacity permits. This program will be expanded to five additional DHS CHCs and Multi-service Ambulatory Care Centers.. DMH also plans to contract with selected PPPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, the vehicle will be through

Waiver Element/Plan	Status
	amendments to current DHS HWLA contracts. However DMH will work to develop its own contracts with the PPPs for future funding.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	The three departments (DHS, DMH and DPH) have initiated meetings and will work to identify pilot program sites for patient-centered behavioral health homes.

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WILLIAM T FUJIOKA
Chief Executive Officer

March 10, 2011

TO: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: William T Fujioka
Chief Executive Officer

STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of the Departments of Mental Health (DMH) and Public Health to report back to the Board within 30 days, and monthly thereafter, on a proposed plan to implement the 1115 Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with L.A. Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health, and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the

Waiver implementation plans, this item will be addressed in the monthly updates provided for the November 16, 2010, motion outlined above.

We initially reported to your Board on November 31, 2010, and our most recent update was dated January 31, 2011, which was presented to your Board on February 1, 2011, as a discussion item. This status update represents our efforts for the month of February 2011.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010, and many details of this Waiver are still being addressed. Although details have not been finalized, the Health and Mental Health Services departments are continuing to work on the 12 critical elements/plans of this important initiative.

In our previous report, we prepared a summary and status for each of the 12 components, and we have updated the summary (Attachment) with the most recent information. Three items that we are highlighting during this period include efforts associated with the Low Income Health Programs (LIHP), Delivery System Reform Incentive Payment Pool (DSRIP), and care for seniors and persons with disabilities (SPDs).

- LIHP - the application was prepared and submitted to the State by the February 14, 2011, deadline. Next steps on the LIHP element include: 1) application approval from the State expected on April 8, 2011; 2) contract negotiations; and 3) program implementation July 1, 2011.

- DSRIP – three of four DSRIP categories were finalized by CMS, and DHS submitted its proposal for the three categories on February 18, 2011. DHS identified 11 projects, each containing several milestones, across the three categories.

- SPDs – this Office and DHS previously recommended that the County and the Local Initiative Health Plan of Los Angeles County, dba L.A. Care Health Plan (L.A. Care) present to your Board a provider agreement with L.A. Care for the Medi-Cal SPDs. In this agreement, the County will be a network provider for L.A. Care, who will assign these beneficiaries directly to County facilities. The County negotiating team has been meeting weekly with the L.A. Care team, and they have agreed on the components of the Division of Financial Responsibility and will soon have the initial four-month contract period rates negotiated.

Provider agreements are being finalized, and on March 1, 2011, your Board delegated authority to the Director of DHS to negotiate and execute Medi-Cal managed care provider agreements with L.A. Care for SPDs, effective March 1, 2011, through September 30, 2014.

The next status report to your Board will be provided by DHS, and it is targeted for April 1, 2011.

If you have any questions, please contact me or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160.

WTF:SAS
MLM:gl

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Public Health

031011_HMHS_MBS_REPORT ON WAIVER IMPLEMENTATION

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011. Application approval is expected from the State on April 8, 2011, with contract negotiations to follow. DHS expects to implement its program on July 1, 2011. DHS will build upon its existing Healthy Way LA (HWLA) program, which currently has 53,000 active members who will be grandfathered into the new program. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. The DHS Ambulatory Care Team is reviewing the required scope of services and access standards to develop an implementation plan for the MCE. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity.

Waiver Element/Plan	Status
	DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. A train the trainer session was held on February 10, 2011 for DMH staff on HWLA eligibility requirements and enrollment procedures. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Discussions with the PPPs are underway to determine the payment methodology. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS has initiated negotiations with Antelope Valley Hospital, UCLA, and a private hospital in the east San Gabriel Valley. If negotiations are not successful, the County must provide transportation to County hospitals for patients residing in those areas. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and PPPs are discussing alternative payment methodologies that may be permitted under the Waiver.

Waiver Element/Plan	Status
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	DHS developed its DSRIP milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. Three of four DSRIP categories have been finalized by CMS, and DHS submitted its proposal for those three categories on February 18, 2011. DHS identified a total of eleven projects (each containing several milestones) across the three categories: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; 8) Improve severe sepsis detection and management; 9) Central line-associated bloodstream infection prevention; 10) Reduce complications of surgical procedures; and 11) Venous thromboembolism prevention and treatment. The final category is expected to be submitted by March 31, 2011. CMS approval on all four categories is expected in April, 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. As part of the development of the DSRIP plan for the County, DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to

Waiver Element/Plan	Status
	develop proposals for worker training for consideration within the DSRIP.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State plans to begin mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams have agreed on the components of the "Division of Financial Responsibility (DOFR)", and will soon have the initial four-month contract period rates negotiated. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. Examples of specific action steps currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is scheduled for staff in the pilot medical home clinics.
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) are meeting and will be evaluating the technical assistance needs once an initial framework is developed (refer to item #11).
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (approximately 53,000 active members with services in the past year) will be grandfathered into the new MCE program. DHS projects enrollment to reach 130,000 by June, 2012. Existing DHS and PPP patients will be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care are underway regarding expectations for the SPD enrollment into managed care. The key objective of the County is retaining the approximately 27,600 patients who use DHS for their care and another 2,700 who receive primary care from the PPPs and obtain specialty and

Waiver Element/Plan	Status
	inpatient care at DHS.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	DHS developed a Waiver oversight staffing plan for implementation, monitoring, and reporting on Waiver milestones and programs. This plan will be discussed with the CEO in March.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	DHS is developing a plan with timeline for infrastructure investments needed to achieve implementation of all aspects of the Waiver. The plan is expected to be submitted to the Board by March 31, 2011.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center in December, 2010, and Roybal Comprehensive Health Center in February, 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to four additional DHS

Waiver Element/Plan	Status
	CHCs and Multi-service Ambulatory Care Centers. DMH also plans to contract with selected PPPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, the vehicle will be through amendments to current DHS HWLA contracts. However DMH will work to develop its own contracts with the PPPs for future funding. HWLA members will be screened for possible mental health services needs within their assigned medical home. If the mental health screening is positive the patient will be referred to DMH providers for a mental health assessment. At DHS facilities with co-located DMH staff the mental health assessment will be conducted on-site. Depending on the mental health needs of the patient, the mental health services may also be provide on-site or at a DMH directly operated or contract site that provides more specialized and intensive mental health services. It is expected that a similar process will be followed in PPP locations with integrated mental health services. HWLA members seen at DHS and PPP sites without integrated mental health services will be referred to DMH directly operated or contracted providers for mental health assessments and services. DHS care coordination staff will work closely with DMH to track referrals and to share information between DMH and DHS providers to manage the care of patients. In addition, HWLA members who are already receiving DMH services will be identified and DHS care coordinators will work with DMH providers to share information and coordinate care when indicated. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below. DHS and DMH are meeting regularly to develop enrollment, referral, and care coordination processes. An operations manual for the delivery of specialty mental health services to HWLA members is under development. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside

Waiver Element/Plan	Status
	the scope of the LIHP.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. A list of the existing behavioral health care homes and a map showing their locations in Los Angeles County is attached to this memo. In addition to these examples, DMH is gathering information regarding successful models implemented in other counties as a basis for future planning. During the week of February 7, a preliminary conference call was held with DMH, DHS and DPH in order to identify the goals and outcomes of a stakeholder group regarding possible expansion of patient-centered behavioral health care homes. It is anticipated that this group, which will include representatives from DMH and DHS contract providers, unions, and all three Departments, will be convened in mid-March

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

April 6, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-

centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31 and March 10, 2011. This status update represents our efforts for the month of March 2011.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010 and many details of this Waiver are still being addressed. Although some details have not been finalized, the Health and Mental Health Services departments are continuing to work on the 12 critical elements/plans of this important initiative, as contained in the Board motions. The attachment contains the most recent information on each of these 12 components.

The next status report to your Board is targeted for May 1, 2011.

If you have any questions, please contact me.

MHK:JFS:jp:

Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Mental Health
Public Health

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011. Application approval is expected from the State on April 8, 2011, with contract negotiations to follow. DHS expects to implement its program on July 1, 2011. DHS will build upon its existing Healthy Way LA (HWLA) program, which currently has 55,000 active members who will be grandfathered into the new program. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. The DHS Ambulatory Care Team is reviewing the required scope of services and access standards to develop an implementation plan for the MCE. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity.

Waiver Element/Plan	Status
	DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. A train the trainer session was held on February 10, 2011 for DMH staff on HWLA eligibility requirements and enrollment procedures. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and PPPs are discussing alternative payment methodologies that may be permitted under the Waiver, and other contract provisions. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS has ongoing negotiations with Antelope Valley Hospital, UCLA, and a private hospital in the east San Gabriel Valley. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO).

Waiver Element/Plan	Status
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	DHS developed its DSRIP milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. All four DSRIP categories have been finalized by CMS; DHS submitted its proposal for three of the four categories on February 18, 2011. DHS identified a total of eleven projects (each containing several milestones) across the three categories: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; 8) Improve severe sepsis detection and management; 9) Central line-associated bloodstream infection prevention; 10) Reduce complications of surgical procedures; and 11) Venous thromboembolism prevention and treatment. The fourth and final category has been finalized and will include reporting requirements in the following areas: patient experience; care coordination; preventive health; and at-risk populations. The DHS proposal is due on April 15, 2011. CMS approval of the proposals is expected in April, 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP.

Waiver Element/Plan	Status
	The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. As part of the development of the DSRIP plan for the County, DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to develop proposals for worker training for consideration within the DSRIP.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State plans to begin mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams have agreed on the components of the "Division of Financial Responsibility (DOFR)", and will have the initial four-month contract period rates negotiated in April. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The new agreement will be effective May 1, 2011.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. Examples of specific action steps currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is underway for staff in the pilot medical home clinics.
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) are meeting and will be evaluating the technical assistance needs once an initial framework is developed (refer to item #11).
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (approximately 55,000 active members with services in the past year) will be grandfathered into the new MCE program. DHS projects enrollment to reach 130,000 by June, 2012. Existing DHS and PPP patients will be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services.

Waiver Element/Plan	Status
	Negotiations with LA Care are underway regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. DHS is offering community partners (PPP) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting for the LIHP are being incorporated into the new Ambulatory Care division, using existing resources of the health care coverage initiative (Healthy Way LA). One of the initial projects for the new Deputy Director for Strategic Planning will be to develop the full plan for monitoring and reporting of the DSRIP.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. DHS staff continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available.

Waiver Element/Plan	Status
	DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, and Roybal CHC in February, 2011. Long Beach CHC began providing services in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also plans to contract with selected PPPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, the vehicle will be through amendments to current DHS HWLA contracts. However DMH will work to develop its own contracts with the PPPs for future funding. HWLA members will be screened for possible mental health services needs within their assigned medical home. If the mental health screening is positive the patient will be referred to DMH providers for a mental health assessment. At DHS facilities with co-located DMH staff the mental health assessment will be conducted on-site. Depending on the mental health needs of the patient, the mental health services may also be provide on-site or at a DMH directly operated or contract site that provides more specialized and intensive mental health services. It is expected that a similar process will be followed in PPP locations with integrated mental health services. HWLA members seen at DHS and PPP sites without integrated mental health services will be referred to DMH directly operated or contracted providers for mental health assessments and services. DHS care coordination staff will work closely with DMH to track referrals and to share information between DMH and DHS providers to manage the care of patients. In addition, HWLA members who are already receiving DMH services will be identified and DHS care coordinators will work with DMH providers to share information and coordinate care when indicated. HWLA members may also receive services through the patient centered

Waiver Element/Plan	Status
	behavioral health home pilot program discussed below. DHS and DMH are meeting regularly to develop enrollment, referral, and care coordination processes. An operations manual for the delivery of specialty mental health services to HWLA members is under development. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. In addition to these examples, DMH is gathering information regarding successful models implemented in other counties as a basis for future planning. During the week of February 7, a preliminary conference call was held with DMH, DHS and DPH in order to identify the goals and outcomes of a stakeholder group regarding possible expansion of patient-centered behavioral health care homes. It is anticipated that this group, which will include representatives from DMH and DHS contract providers, unions, and all three Departments, will be convened in April.

Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

John F. Schunhoff, Ph.D.
Chief Deputy Director

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www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

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May 5, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: for Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31, March 10, and April 6, 2011. This status update represents our efforts for the month of April 2011.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010 and many details of this Waiver are still being addressed. Although some details have not been finalized, the Health and Mental

Health Services departments are continuing to work on the 12 critical elements/plans of this important initiative, as contained in the Board motions. The attachment contains the most recent information on each of these 12 components.

The next status report to your Board is targeted for June 1, 2011.

If you have any questions, please contact me.

MHK:JFS:jp

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Mental Health
Public Health

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011 and received a letter of Initial Approval on April 11, 2011. The next step is an Authorization Process to ensure that program requirements will be met, and a Contract Process that will continue on a concurrent track with the Authorization Process. DHS will implement its program on July 1, 2011. DHS is building upon its existing Healthy Way LA (HWLA) program, which currently has 60,000 active members who will be grandfathered into the new program. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. The DHS Ambulatory Care Team is developing and implementing an implementation plan for the MCE, to meet the required scope of services and access standards. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA's mental health benefit includes the full range of Medi-Cal reimbursable mental health

Waiver Element/Plan	Status
	rehabilitative services based on medical necessity. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. A train the trainer session was held on February 10, 2011 for DMH staff on HWLA eligibility requirements and enrollment procedures. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Discussions with the PPPs are nearing conclusion including the payment methodology and other contract provisions. Contracts are expected to be finalized by mid-May and are targeted for the Board agenda of May 31, 2011. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS has ongoing negotiations with Antelope Valley Hospital, UCLA, and a private hospital in the east San Gabriel Valley. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a

Waiver Element/Plan	Status
	bundled or capitated payment. For the LIHP, DHS and PPPs are discussing alternative payment methodologies that may be permitted under the Waiver.
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	DHS developed its DSRIP milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. All four DSRIP categories have been finalized by CMS; DHS submitted its proposal for three of the four categories on February 18, 2011. DHS identified a total of eleven projects (each containing several milestones) across the three categories: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; 8) Improve severe sepsis detection and management; 9) Central line-associated bloodstream infection prevention; 10) Reduce complications of surgical procedures; and 11) Venous thromboembolism prevention and treatment. The fourth and final category has been finalized and will include reporting requirements in the following areas: patient experience; care coordination; preventive health; and at-risk populations. DHS received verbal approval of its proposal from CMS on March 11, 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion.

Waiver Element/Plan	Status
to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to develop proposals for worker training for FY 2011-12 which support the implementation of the Waiver.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State will begin mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams completed work on the two provider agreements, which were executed last week, effective May 1, 2011. The agreements contain the negotiated "Division of Financial Responsibility (DOFR)", and have the initial four-month contract period rates. Amendments to the agreements will be needed when the next set of rates are announced by the State and when the State, the County and LA Care are able to negotiate a risk-sharing agreement
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. Examples of specific action steps currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is scheduled for staff in the pilot medical home clinics.

Waiver Element/Plan	Status
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) continues to meet to pursue integration of mental health and substance abuse-related services.
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (approximately 55,000 active members with services in the past year) will be grandfathered into the new MCE program. Existing DHS and PPP patients will be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care are underway regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. DHS is offering community partners (PPP) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting are being incorporated into the new Ambulatory Care division, using existing resources. One of the initial projects for the new Deputy Director for Strategic Planning will be to develop the full plan for monitoring and reporting of the DSRIP.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. These projections have not changed in the draft DHS fiscal outlook to be presented on May 17. DHS staff continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal

Waiver Element/Plan	Status
	reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, Roybal CHC in February, 2011, and Long Beach CHC in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also plans to contract with selected PPPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, DMH will provide training support to PPPs through amendments to current DHS PPP contracts during the current Fiscal Year. DMH is in the process of developing contracts with the PPPs for ongoing service delivery funding beginning in Fiscal Year 2011-12. . HWLA members will be screened for possible mental health services needs within their assigned medical home. If the mental health screening is positive the patient will be referred to DMH providers for a mental health assessment. At DHS facilities with co-located DMH staff the mental health assessment will be conducted on-site. Depending on the mental health needs of the patient, the mental health services may also be provide on-site or at a DMH directly

Waiver Element/Plan	Status
	operated or contract site that provides more specialized and intensive mental health services. It is expected that a similar process will be followed in PPP locations with integrated mental health services. HWLA members seen at DHS and PPP sites without integrated mental health services will be referred to DMH directly operated or contracted providers for mental health assessments and services. DHS care coordination staff will work closely with DMH to track referrals and to share information between DMH and DHS providers to manage the care of patients. In addition, HWLA members who are already receiving DMH services will be identified and DHS care coordinators will work with DMH providers to share information and coordinate care when indicated. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below. DHS and DMH are meeting regularly to develop enrollment, referral, and care coordination processes. An operations manual for the delivery of specialty mental health services to HWLA members is under development. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. In addition to these examples, DMH is gathering information regarding successful models implemented in other counties as a basis for future planning. During the week of February 7, a preliminary conference call was held with DMH, DHS and DPH in order to identify the goals and outcomes of a stakeholder group regarding possible expansion of patient-centered behavioral health care homes. Two meetings of this group, which includes representatives from DMH and DHS contract providers, unions, and all three Departments, were convened during April 2011.

Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
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June 9, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31, March 10, April 6, and May 5, 2011. This status update represents our efforts for the month of May 2011.

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011 and received a letter of Initial Approval on April 11, 2011. The next step is an Authorization Process to ensure that program requirements will be met, and a Contract Process that will continue on a concurrent track with the Authorization Process. To date the authorization process has included documentation of the provider network, geographic access, cultural sensitivity, and Due Process policies. DHS will implement its program on July 1, 2011. DHS is building upon its existing Healthy Way LA (HWLA) program, which currently has 65,000 active members who will be grandfathered into the new program. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. The DHS Ambulatory Care Team is developing and implementing an implementation plan for the MCE, to meet the required scope of services and access standards. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA's mental

Waiver Element/Plan	Status
	health benefit includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. A train the trainer session was held on February 10, 2011 for DMH staff on HWLA eligibility requirements and enrollment procedures. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Discussions with the PPPs have been productive and include the payment methodology and other contract provisions. Contracts were on the June 7, 2011 Board agenda and continued to the Board agenda of June 14, 2011. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS is finalizing negotiations with Antelope Valley Hospital and Santa-Monica-UCLA Medical Center. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). DHS has not been able to complete negotiations for with a private hospital for scheduled inpatient services for patients residing in the east San Gabriel Valley. Thus, on June 7, the Board approved delegated authority to enter into transportation services for these

Waiver Element/Plan	Status
	patients. Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and Community Partners (CPs) are discussing alternative payment methodologies that may be permitted under the Waiver.
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	DHS developed its DSRIP milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. All four DSRIP categories have been finalized by CMS; DHS submitted its proposal for three of the four categories on February 18, 2011. DHS identified a total of eleven projects (each containing several milestones) across these three categories: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; 8) Improve severe sepsis detection and management; 9) Central line-associated bloodstream infection prevention; 10) Reduce complications of surgical procedures; and 11) Venous thromboembolism prevention and treatment. The fourth and final category has been finalized based on negotiations between CAPH, the State, and CMS, with input obtained from DHS. Reporting requirements for this category are standardized across all public hospitals in California and include metrics in the following areas: patient experience; care coordination; preventive health; and at-risk populations. The patient experience milestones will require DHS to measure and report outpatient satisfaction in a consistent manner across all hospitals using CG-CAHPS, a widely accepted survey tool. Milestones within the care coordination, preventive health, and at-risk population categories will require

Waiver Element/Plan	Status
	DHS to expand its capabilities in collecting and reporting outpatient quality data. The Demonstration Year 6 (FY 2010-2011) year-end report was submitted to the State on May 15, 2011. Demonstration Year 7 will begin July 1, 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to develop proposals for worker training for FY 2011-12 which support the implementation of the Waiver. The agreement for this was on the Board's June 7 agenda, continued to June 14, 2011.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State began mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams completed work on the two provider agreements, which were executed, effective May 1, 2011. The agreements contain the negotiated "Division of Financial Responsibility (DOFR)", and have the initial four-month contract period rates. Amendments

Waiver Element/Plan	Status
	to the agreements will be needed when the next set of rates are announced by the State and when the State, the County and LA Care are able to negotiate a risk-sharing agreement.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. The new classification of Certified Medical Assistant was created and an exam is open for applicants. Other efforts currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is completed for staff in the pilot medical home clinics and training is underway for the coaches who will help to spread the medical home model through the remainder of the system.
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) continues to meet to pursue integration of mental health and substance abuse-related services.
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (approximately 65,000 active members with services in the past year) will be grandfathered into the new MCE program. Existing DHS and CP patients will be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care were completed regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. Effective June 1, 2011, 4,619 SPD L.A. Care enrollees were assigned to DHS for their primary care homes. DHS is offering community partners (PPP) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.

Waiver Element/Plan	Status
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting are being incorporated into the new Ambulatory Care division, using existing resources. The new Deputy Director for Strategic Planning is responsible for oversight of DHS-wide efforts to achieve DSRIP milestones and will be working closely with the leadership of each individual initiative to ensure DHS meets and reports on all milestones on time.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. These projections were also included in the DHS fiscal outlook presented on May 17. DHS staff continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, Roybal CHC in February, 2011, and Long Beach CHC in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three

Waiver Element/Plan	Status
	additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also plans to contract with selected CPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, DMH will provide training support to CPs through amendments to current DHS CP contracts during the current Fiscal Year. DMH is preparing contracts with the CPs for ongoing service delivery funding beginning in Fiscal Year 2011-12. These contracts are the subject of recommendations in an A-4 Board memo for the June 14, 2011 agenda. HWLA members will be screened for possible mental health services needs within their assigned medical home. If the mental health screening is positive the patient will be referred to DMH providers for a mental health assessment. At DHS facilities with co-located DMH staff the mental health assessment will be conducted on-site. Depending on the mental health needs of the patient, the mental health services may also be provided on-site or at a DMH directly operated or contract site that provides more specialized and intensive mental health services. It is expected that a similar process will be followed in CP locations with integrated mental health services. HWLA members seen at DHS and CP sites without integrated mental health services will be referred to DMH directly operated or contracted providers for mental health assessments and services. DHS care coordination staff will work closely with DMH to track referrals and to share information between DMH and DHS providers to manage the care of patients. In addition, HWLA members who are already receiving DMH services will be identified and DHS care coordinators will work with DMH providers to share information and coordinate care when indicated. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below. DHS and DMH are meeting regularly to develop enrollment, referral, and care coordination processes. An operations manual for the delivery of specialty mental health services to HWLA members is under development. DPH decided not to include substance abuse benefits in the LIHP at this time;

Waiver Element/Plan	Status
	however, the departments will continue to pursue integrated services outside the scope of the LIHP.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. Concurrently, the Department initiated the implementation of the MHSA-funded Innovations Plan which will enable the Department to pilot several models for integrated behavioral health homes. Outcome evaluations will be conducted on these approaches which include an integrated mobile health team, an integrated clinic model and models proposed by underrepresented populations. Finally, in collaboration with DHS and DPH, a behavioral health home workgroup was convened. Workgroup members include DMH, DHS and Public Health staff, representatives of several unions, contract providers and social service representatives. During the first two meetings, participants identified core elements of behavioral health homes to be implemented in Los Angeles. The workgroup will meet for a final session to identify actions that can be initiated now in order to prepare Los Angeles County for the potential implementation of behavioral health homes in 2014.

Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

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Chief Deputy Director

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July 13, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31, March 10, April 6, May 5, and June 6, 2011. This status update represents our efforts for the month of May 2011.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010 and many details of this Waiver are still being addressed. Although some details have not been finalized, the Health and Mental Health Services departments are continuing to work on the 12 critical elements/plans of this important initiative, as contained in the Board motions. The attachment contains the most recent information on each of these 12 components.

The most important accomplishments since the previous report were achieving authorization from the State for the Low Income Health Program and implementing the new Healthy Way LA- Matched program, effective July 1, 2011, including mental health services.

The next status report to your Board is targeted for August 1, 2011.

If you have any questions, please contact me.

MHK:JFS:jp

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Mental Health
Public Health

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011 and received a letter of Initial Approval on April 11, 2011. The next step was an Authorization Process to ensure that program requirements will be met, and a Contract Process on a concurrent track with the Authorization Process. DHS has received notice that is met all program requirements by the July 1, 2011 deadline. DHS implemented its program on July 1, 2011. A contract template was completed by the State and County-specific contracts are expected to be signed by September 30, 2011. DHS is building upon its existing Healthy Way LA (HWLA) program. A total of 61,875 active members have been grandfathered into the new program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services are available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA's mental health benefit includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment.

Waiver Element/Plan	Status
	DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. New HWLA agreements with Community Partners, covering HWLA Matched and Unmatched Services were approved by the Board on June 14, 2011 replacing previous PPP contracts, HWLA contracts and SB 474 contracts. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. An agreement has been completed and signed with Antelope Valley Hospital. DHS is finalizing negotiations with Santa-Monica-UCLA Medical Center and with a private hospital for patients residing in the east San Gabriel Valley. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and Community Partners (CPs) are discussing alternative payment methodologies that may be permitted under the Waiver.

Waiver Element/Plan	Status
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	The DSRIP includes numerous milestones within 15 projects that are grouped into four categories. These projects are: Category I: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; Category II: 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; Category III: 8) Measure Patient/Care Giver Experience (Outpatient); 9) Measure Care Coordination; 10) Measure Preventive Health Interventions; 11) Measure Interventions for At-Risk Populations; Category IV: 12) Improve severe sepsis detection and management; 13) Central line-associated bloodstream infection prevention; 14) Reduce complications of surgical procedures; and 15) Venous thromboembolism prevention and treatment. Demonstration Year 7 [the second year of the DSRIP] began July 1, 2011 and will end June 30, 2012.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated

Waiver Element/Plan	Status
community colleges and universities.	entity] to develop proposals for worker training for FY 2011-12 which support the implementation of the Waiver. The agreement for this was on the Board's June 7 agenda, continued to June 14, 2011.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State began mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams completed work on the two provider agreements, which were executed, effective May 1, 2011. The agreements contain the negotiated "Division of Financial Responsibility (DOFR)", and have the initial four-month contract period rates. Amendments to the agreements will be needed when the next set of rates are announced by the State and when the State, the County and LA Care are able to negotiate a risk-sharing agreement.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. The new classification of Certified Medical Assistant was created and an exam is open for applicants. Other efforts currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is completed for staff in the pilot medical home clinics and training is underway for the coaches who will help to spread the medical home model through the remainder of the system.
7. Technical assistance needed to ensure that the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) continues to meet to pursue integration of mental health and substance abuse-related services.

Waiver Element/Plan	Status
8. Enrollment, revenue and expenditure projections.	A total of 61,875 existing HWLA members were grandfathered into the new MCE program. Existing DHS and CP patients will initially be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care were completed regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. As of July 1, 2011, the net SPD L.A. Care enrollees assigned to DHS for their primary care homes is 8,322, significantly above the target. DHS is offering community partners (PPPs) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting are being incorporated into the new Ambulatory Care division, using existing resources. The Deputy Director for Strategic Planning is responsible for oversight of DHS-wide efforts to achieve DSRIP milestones and is working closely with the leadership of each individual initiative to ensure DHS meets and reports on all milestones on time.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. These projections were also included in the DHS fiscal outlook presented on May 17. DHS staff will continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services are available to HWLA members effective July 1, 2011. The mental health delivery system is operating through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will

Waiver Element/Plan	Status
	preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, Roybal CHC in February, 2011, and Long Beach CHC in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also contracted with selected CPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, DMH provided training support to CPs through amendments to existing DHS CP contracts during Fiscal Year 2010-11. DMH also developed contracts with the CPs for ongoing service delivery funding beginning in Fiscal Year 2011-12. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. Concurrently, the Department initiated the implementation of the MHSA-funded Innovations Plan which will enable the Department to pilot several models for integrated behavioral health homes. Outcome evaluations will be conducted on these approaches which include an integrated mobile health team, an integrated clinic model and models proposed by

Waiver Element/Plan	Status
	underrepresented populations. Finally, in collaboration with DHS and DPH, a behavioral health home workgroup was convened. Workgroup members include DMH, DHS and Public Health staff, representatives of several unions, contract providers and social service representatives. During the first two meetings, participants identified core elements of behavioral health homes to be implemented in Los Angeles. The workgroup will meet for a final session to identify actions that can be initiated now in order to prepare Los Angeles County for the potential implementation of behavioral health homes in 2014.

Health Services
LOS ANGELES COUNTY

August 10, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE IMPLEMENTATION OF THE 1115 MEDICAID WAIVER**

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

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On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health (DMH) and Public Health (DPH) to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). On December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.

The CEO initially reported to your Board on the first two motions referenced above on November 31, 2010, with updates dated January 31, March 10, April 6, May 5, June 9, and July 13, 2011. These reports were structured in accordance with 12 specific planning elements in the two motions. Now that we are in the implementation phase on all elements, we plan to focus the reports on the most updated information relevant to these motions such as major developments and enrollment trends in Healthy Way LA (HWLA) and Seniors and Persons with Disabilities (SPDs) in managed care, and progress on key components of the Waiver, such as the Delivery System Reform Incentive Payment Pool (DSRIP). We will target distribution for the 15th of each month.

HEALTHY WAY LA – LOW INCOME HEALTH PROGRAM (LIHP)

DHS received notice that it met all program requirements by the July 1, 2011 deadline and DHS implemented its program on July 1, 2011. A contract template was completed by the State and County-specific contracts are expected to be signed by September 30, 2011.

The HWLA-Matched network consists of DHS facilities, Community Partner (CP) clinics, and contracted hospitals. New HWLA agreements with CPs, covering HWLA Matched and Unmatched Services were approved by your Board on June 14, 2011 replacing previous Public Private Partner (PPP) contracts, HWLA

contracts and SB 474 contracts. An agreement was signed with Antelope Valley Hospital. DHS is finalizing negotiations with Santa-Monica-UCLA Medical Center and with a private hospital for patients residing in the east San Gabriel Valley.

A total of 61,875 active members were grandfathered into the new program.

Starting July 1, the new HWLA program began. DHS launched Operation Full Enrollment, a three-month "all hands on deck" campaign to ramp up enrollment, utilizing as many DHS staff as possible in the process. DHS facilities have trained more staff to take HWLA applications and to communicate with potentially eligible, existing patients, as part of our "in-reach" work. During the month of July, 8,878 "in-reach" contacts were made with patients, and a total of 3,447 new enrollments were approved, over double the monthly average from the previous 12 months. In addition, 393 individuals were enrolled at CP clinics, and 173 at DMH facilities.

There are new, more time-consuming enrollment requirements under this version of HWLA, compared with the previous program. We estimate a backlog of well over 1,000 completed applications at DHS and CP sites. Key barriers creating the backlog have been identified and are being addressed. We have been doing site visits of DHS and CP clinics to learn and share best practices and to find ways to improve the process and make enrollment more efficient and easy for the patients.

ENROLLMENT OF SPDs IN DHS

As of July 14, 2011, the net SPD L.A. Care enrollees assigned to DHS for their primary care homes is 8,231, compared with a two-month target of 5,000. The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have previously received care from DHS. However, there is a challenge with membership assignment at the State level to meet this original intent. A recent analysis showed that, of the assigned SPD patients, only 52% have used a DHS facility and only 12% have visited a DHS primary care provider in the past 18 months. Therefore, many of the new SPD enrollees are not familiar with the DHS system. The new influx of SPD patients to DHS has resulted in a noticeable increase in calls to DHS. In order to improve services for patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes.

The next status report to your Board is targeted for September 15, 2011.

If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:JFS:jp/vlr

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Department of Mental Health
Department of Public Health

Health Services
LOS ANGELES COUNTY

September 22, 2011

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TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE IMPLEMENTATION OF THE 1115 MEDICAID WAIVER**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). On December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. This report is the latest monthly report in response to these motions.

HEALTHY WAY LA – LOW INCOME HEALTH PROGRAM (LIHP)

DHS received notice that it met all program requirements by the July 1, 2011 deadline and DHS implemented its program on July 1, 2011. A contract template was completed by the State and County-specific contracts are expected to be signed by September 30, 2011.

The HWLA-Matched network consists of DHS facilities, Community Partner (CP) clinics, and contracted hospitals. New HWLA agreements with CPs, covering HWLA Matched and Unmatched Services were approved by your Board on June 14, 2011 replacing previous Public Private Partner (PPP) contracts, HWLA contracts and SB 474 contracts. In addition, on September 20, 2011 your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements, and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White CARE Act program clients to HWLA. DHS is in the process of amending contracts and offering new contracts accordingly.

Prior to the start of the new HWLA program, a total of 62,052 active HWLA members continued into the new program.

The new HWLA program began on July 1 and DHS launched "Operation Full Enrollment," a campaign aimed at ramping up enrollment and purposefully utilizing as many DHS staff as possible in the process. DHS facilities cross-trained more staff to take HWLA applications and to communicate with potentially eligible,

existing patients, as part of our "in-reach" work. From July 1 through September 19 of this year 70,251 in-reach patient contacts were made, and a total of 11,054 patients who are seen at DHS clinics met eligibility requirements and were enrolled. The monthly enrollment for July and August was over double the monthly average from the previous 12 months. In order to achieve these high enrollment numbers, over 130 non-HWLA enrollment staff assisted in HWLA enrollment in a part-time or full-time capacity.

In addition, over 5,000 individuals were enrolled at Community Partner clinics, and 653 at DMH facilities.

The new HWLA enrollments have more time-consuming enrollment requirements as compared with the previous program requirements. Process improvements are in place and a number of issues have been addressed. For example, backlogs from Community Partners have been reduced and improved functionality of the web-based enrollment application has been implemented. DHS now hosts a weekly conference call with DHS staff, Community Partners, and DMH to share best practices and address impending issues. An updated website (www.ladhs.org/hwla) provides patient and consumer information and regular training schedules and includes YouTube training videos. In addition, we will provide on-site support for Community Partner clinics when needed. Through these combined efforts, submission of completed HWLA applications to DHS from Community Partners has increased, and incomplete applications along with backlogs of completed applications have significantly decreased.

ENROLLMENT OF SPDs IN DHS

In the first four months of SPD enrollment (June 1 through September 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers is 12,200 (41% of our annual enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have a previously received care from DHS. However, there is a challenge with membership assignment at the State level to meet this original intent. An analysis of June and July data showed that of the assigned SPD patients, only 52% have used a DHS facility and only 12% have visited a DHS primary care provider in the past 18 months. Therefore, many of the new SPD enrollees are not familiar with the DHS system. The new influx of SPD patients to DHS has resulted in a noticeable increase in calls to DHS as the patients were unsure on how to access DHS services or wanted to continue care with their current (non-DHS) primary care provider and/or specialists. In order to improve services for patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

DHS continues to make progress toward completing milestones for the DSRIP component of the 1115 Waiver. Activities and accomplishments from the first six months of Demonstration Year 7 will be reported in the Spring of 2012. A status update on individual DSRIP milestones is attached.

IMPROVING PRIMARY CARE AND SPECIALIST ACCESS

As we continue to transform our system to meet future health care reform requirements and ultimately provide access to our patients, one immediate measure initiated by the Ambulatory Care Network in partnership with the specialty clinics is to improve specialty care access. For the last two months DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS Emergency

rooms that did not have a primary care provider. Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by both the primary care provider and specialist. In collaboration with our Community Partners, who provided DHS with 15,124 appointment slots, DHS identified and linked approximately 14,000 patients to Community Partners. This linkage process was based on the availability of appointment slots as provided by the Community Partner and the geographic proximity to the patient's home. This effort takes advantage of the primary care resources available through the Community Partners and improves the ability of DHS and our Community Partners to provide effective and cost-efficient patient care services. All affected patients received a letter notifying them of the name of the clinic they had been "assigned" to for their future primary care needs. This process will be repeated on a quarterly basis.

The next status report to your Board is targeted for October 14, 2011. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:WS:jp
Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Department of Mental Health
Department of Public Health

DSRIP DY 7 Milestones		
Project	**Milestone**	**September 2011 update**
Category I		
Implement and Utilize Disease Management Registry Functionality	Disease management registry functionality is available in at least one clinic in each of at least 8 DHS facilities.	Registry vendor contract due to be completed by early October, including the technical modifications statement of work. Initial implementation should start by December.
	At least 55% of patients with diabetes, heart failure or asthma seen in the clinics with registry access are entered into the registry.	As the registry application is implemented, all empaneled patients (including with diabetes, heart failure, or asthma) within medical homes will be entered into the registry.
Enhance Urgent Medical Advice	Expand access to NAL by 10% over baseline.	Flyers and refrigerator magnets are now being included in new member packets, which should increase NAL awareness and utilization. Data on NAL usage rates is being collected and will be trended on a quarterly basis.
	Increase by 10% over baseline the number of NAL patient contacts who reported intent to go to the ED for non-emergent conditions but were redirected to non-ED resources.	
Enhance Coding and Documentation for Quality Data	Implement HIPAA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions.	Harbor-UCLA, the last of the facilities to have 5010 capabilities implemented, will go live by mid-October 2011.
	Train staff on the changes in work flow (related to HIPAA 5010).	DHS employees require only minimal training on workflow changes related to implementation of HIPAA 5010; this will be provided by our contracted billing and IT vendors in late 2011/early 2012 and documented by Finance staff. More substantial training is required of DHS contracted billing vendors. Medicare billing vendors are currently in 5010 testing. Regarding Medi-Cal billing, the State has not yet released the required 5010 Companion Guide required for 5010 programing and testing. Upon the State's release of the 5010 Companion Guide our billing vendors will commence programming and testing. Once programming and testing is complete, vendors will provide training to appropriate staff mid-December 2011.
Enhance Performance Improvement and Reporting Capacity	Participate in CHART or other statewide, public hospital or national clinical database for standardized data sharing.	Harbor UCLA, LAC-USC, and Olive View Medical Center report to CHART (California Hospital Assessment and Reporting Taskforce). Rancho reports Functional Independence Measures (FIM) to the Uniform Data System for Medical Rehabilitation.
	Share quality dashboard or scorecard (including patient satisfaction measures) with organizational leadership on a regular basis; post on DHS public website.	Performance measures are continually reported to senior leadership. DHS public website continues to report quality and patient satisfaction data. We will make refinements to these reporting tools in late 2011/early 2012.

DSRIP DY 7 Milestones		
Project	**Milestone**	**September 2011 update**
	Category II	
Expand Medical Home	Ensure at least 20 primary care providers deliver care using the medical home model.	The ACN's initial empanelment exercise has been completed and staff are currently validating patient lists. Once validation is complete, each of our primary care FTEs will be assigned patient panels. We anticipate that all primary care providers within ACN will be empaneled before December 2011. (116 FTEs and 78,500 patients).
	Assign at least 10,000 patients to provider-led medical home teams.	
Expand Chronic Care Management Model	Determine baseline percentage of patients with diabetes, heart failure or asthma with at least one recorded self-management goal.	Awaiting Registry implementation.
	Implement a comprehensive risk-reduction program for patients with diabetes mellitus that includes glycemic, blood pressure and lipid control in primary care. Target patients include those with Diabetes related inpatient admissions and those with high risk score (HgA1c + LDL + BP).	Care kits addressing risk reduction among patients with diabetes have been developed. Care kit training of all ACN primary care clinic staff is currently underway.
	Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types.	Baseline established.
	Determine baseline: Blood pressure control among patients with completed stroke who are empaneled at any primary care medical home with registry access.	Awaiting Registry implementation.
Integrate Physical and Behavioral Health Care	Co-locate mental health services with primary care in 4 LAC DHS directly operated or contract facilities.	Five co-location sites are currently operating (Long Beach, El Monte, Roybal, High Desert, and Humphrey); DMH is recruiting staff for Mid-Valley and planning is underway for MLK and Hudson.
	Track referrals from primary care providers to on-site mental health professionals to be used at the co-location sites.	Preliminary tracking mechanism is in place; it is being further refined in an official Policy and Procedure that is in final stages of development.
	Use joint consultations and treatment planning at co-location sites, and coordinate resources to improve patient education, support, and compliance with the medication regimen.	Joint consultations will be defined as part of the Policy and Procedure document noted above.
	Integrate depression screening to 15% of enrolled patients with diabetes assigned to co-location sites.	New disease management registry to be customized to include ability to track depression screening. Baseline data collection effort not yet initiated. Providers to be educated regarding depression screening as needed as part of the medical home model.
	Ensure at least 70% of initial behavioral health visit appointment waiting times among patients enrolled in DHS medical homes who meet medical necessity criteria are less than 30 business days.	Preliminary data available. Co-located DMH staff are adjusting referral flows in response to high referral volumes at specific co-located clinics in order to achieve mandated access standards for managed care populations.

DSRIP DY 7 Milestones		
Project	**Milestone**	**September 2011 update**
	Category III	
Patient/Care Giver Experience	Undertake the necessary planning, redesign, translation, training, and contract negotiations in order to implement CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) in DY8	DHS is in the initial planning stages of implementing CG-CAHPS.
Care Coordination	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	DHS is refining the data collection methodology needed to track the numerator and denominator for Category III metrics. Two analysts were transferred from CHP to the Office of Planning in early September to focus on data collection, analysis, and reporting for Category III.
	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
Preventive Health	Report the following: Numerator: All female patients age 50 - 74 years who had a mammogram to screen for breast cancer within 24 months Denominator: Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 50 and older who received an influenza immunization during the flu season (September through February) Denominator: Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
At Risk Populations	Report the following: Numerator: All patients age 18 - 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 18 - 75 years with diabetes whose most recent hemoglobin A1c level is in control (<9%) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	

DSRIP DY 7 Milestones		
Project	**Milestone**	**September 2011 update**
Category IV		
Improve Severe Sepsis Detection and Management	Form DHS wide Sepsis Collaborative	Completed
	Revise CME approved curriculum used to train ED nurses and physicians in the detection and treatment of severe sepsis and septic shock patients	Curriculum revised - awaiting CME approval.
	Train 30% of ED nurses and physicians on severe sepsis and septic shock detection and treatment	Training is in process.
	Create Sepsis Resuscitation Order Set that includes the resuscitation bundle elements.	All Facilities have submitted draft orders sets.
	Allocate resources for expert support	Completed
	Allocate resources for data collection methodology development	Completed
	Allocate resources for data collection	Completed
	Report at least 6 months of data collection on Sepsis Resuscitation Bundle to Safety Net Institute (SNI) for purposes of establishing the baseline and setting benchmarks.	Data collection complete, now in validation phase.
	Report the Sepsis Resuscitation Bundle results to the State.	Data to be reported by the end of 2011
Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention	Develop a mandatory curriculum/ used to train and orient physicians in the insertion of central lines	Completed
	Provide ongoing education to ICU staff on care of central lines	Ongoing
	Allocate resources to provide expert support	Completed
	Allocate resources to develop data collection methodology	Completed
	Allocate resources to collect data on implementation of central line bundle	Completed
	Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks.	Completed
	Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks.	Data to be reported by the end of 2011
	Report CLIP results to the State.	Data to be available for reporting by Spring 2012
Reduce Complications of Surgical Procedures	Assess understanding of and compliance with 6 SCIP Core measures for identified procedures using UHC Core Measure Data set	Completed
	Address provider knowledge deficits using a variety of strategies e.g., team training	Team Training scheduled for January 2012.
	Develop dashboard to compare compliance with SCIP Core measures using UHC Core Measure Data for CDPH targeted procedures	In process
	Report at least 6 months of data collection on SSI to SNI for purposes of establishing the baseline and setting benchmarks.	In process
	Report results to the State.	Data to be available for reporting by Spring 2012
Venous Thromboembolism (VTE) Prevention and Treatment	Form DHS VTE prevention collaborative	Completed
	Set general goals and a timeline for construction of and implementation of VTE protocol	Completed
	Allocate resources for expert support	Completed
	Allocate resources to develop VTE data collection methodology	Completed
	Allocate resources to collect data on VTE measures	Completed
	Report at least 6 months of data collection on the VTE management process measures to SNI for purposes of establishing the baseline and setting benchmarks.	Data Collection in process - expected to be completed October 2011
	Report the 5 VTE process measures data to the State.	Data to be reported by the end of 2011

Health Services
LOS ANGELES COUNTY

October 14, 2011

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www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE IMPLEMENTATION OF THE 1115 MEDICAID WAIVER**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). This is the most recent report in response to that motion.

HEALTHY WAY LA – LOW INCOME HEALTH PROGRAM (LIHP)

DHS received notice that it met all program requirements by the July 1, 2011 deadline and DHS implemented its program on July 1, 2011. A contract template of the State and County-specific contracts was completed and signed and is awaiting CMS's signature.

The HWLA-Matched network consists of DHS facilities, Community Partner (CP) clinics, and contracted hospitals. New HWLA agreements with CPs, covering HWLA Matched and Unmatched Services were approved by your Board on June 14, 2011 replacing previous Public Private Partner (PPP) contracts, HWLA contracts and SB 474 contracts. In addition, on September 20, 2011 your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements, and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White CARE Act program clients to HWLA. Accordingly, DHS has provided current and potential HWLA CPs with amended contracts for signature by November 1.

Prior to the start of the new HWLA program, a total of 62,052 active HWLA members continued into the new program.

The new HWLA program began on July 1 and DHS launched "Operation Full Enrollment," a campaign aimed at ramping up enrollment and purposefully utilizing as many DHS staff as possible in the process. Over 130 non-HWLA enrollment staff assisted in HWLA enrollment in a part-time or full-time capacity. Staff assisted in both the DHS and CP enrollment process, depending on greatest need. Based on the first 14 weeks of data, the overall rate of enrollment into HWLA has quadrupled.

Because of the initial success of this campaign, DHS extended Operation Full Enrollment through the month of October and may extend to November. We requested that all temporarily assigned staff continue providing assistance where possible. From July 1 through October 9 of this year 101,945 in-reach patient contacts were made, and over 14,500 patients who are seen at DHS clinics met eligibility requirements and were enrolled. In addition, over 11,600 individuals were enrolled at Community Partner clinics, and over 870 at DMH facilities. In total, over 27,000 new patients have been enrolled into HWLA since July 1.

In order to address concerns with the new enrollment requirements, DHS continues to have regular communication with stakeholders and troubleshoot issues, averaging 50-60 participants for our weekly calls. For example, the significant increase in the Community Partner enrollment in the past month is partially due to the reduction of the backlog achieved by an improved approval process at the Office of Managed Care (OMC) and by other DHS staff doing on-site application review. The website (www.ladhs.org/hwla) is frequently updated, often in response to concerns or common problems among the Community Partners or DHS, and additional trainings have occurred or have been scheduled.

ENROLLMENT OF SPDs IN DHS

In the first five months of SPD enrollment (June 1 to October 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers is 14,041 (48% of our annual enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have previously received care from DHS. However, as stated in prior reports, there is a challenge with membership assignment at the State level to meet this original intent. DHS consistently receives a large number of calls from patients who are unsure how to access DHS services or who want to continue care with their current (non-DHS) primary care provider and/or specialists. In order to improve services for patients, DHS and L.A. Care staff meets regularly and work collaboratively to improve our care coordination and care transition processes.

IMPROVING PRIMARY CARE AND SPECIALIST ACCESS

As we continue to transform our system to meet future health care reform requirements and ultimately provide access to our patients, one measure initiated by the Ambulatory Care Network in partnership with the specialty clinics is to improve specialty care access. Previously, DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS Emergency Rooms who did not have a primary care provider. Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by the primary care provider and specialist. In collaboration with our Community Partners, who

provided DHS with 15,124 appointment slots, DHS identified and linked approximately 13,500 patients to Community Partners. This linkage process was based on the availability of appointment slots as provided by the Community Partner and the geographic proximity to the patient's home. For this upcoming quarter, we received nearly 8,000 appointment slots. DHS staff is working on identifying patients who could be better served with a primary care provider. All affected patients received a letter notifying them of the name of the clinic they had been "assigned" to for their future primary care needs. This process will be repeated on a quarterly basis.

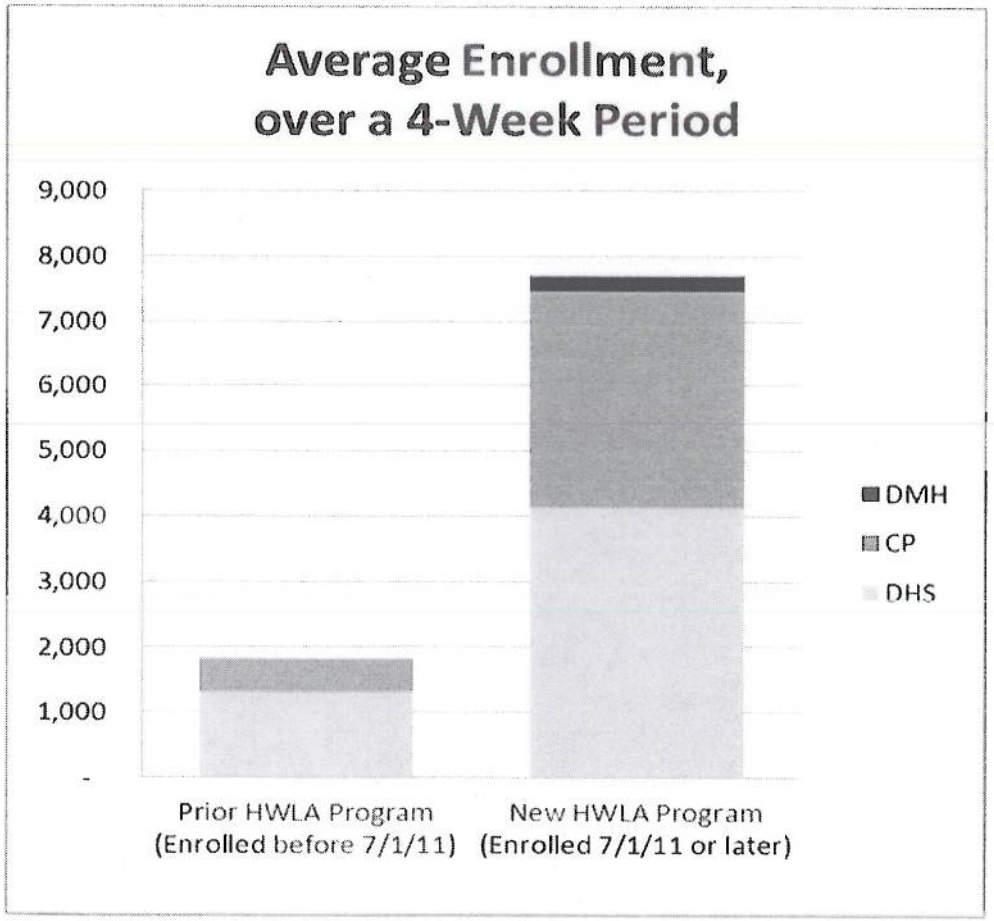
The next status report to your Board is targeted for November 15, 2011. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:AL:vr
Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Department of Mental Health
Department of Public Health

Table 1

Healthy Way LA
LOS ANGELES COUNTY



Health Services
LOS ANGELES COUNTY

November 16, 2011

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TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE IMPLEMENTATION OF THE 1115 MEDICAID WAIVER**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health (DMH) and Public Health (DPH) to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). On December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. This is the latest monthly report in response to these motions.

HEALTHY WAY LA – LOW INCOME HEALTH PROGRAM (LIHP)

Network Update: On June 14, 2011, your Board approved the new HWLA agreements with Community Partners (CP) covering HWLA Matched and Unmatched Services. This new agreement replaced the previous Public Private Partner, HWLA and SB 474 contracts. On September 20, 2011, your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White Care Act program clients to HWLA. We received signed contract amendments from most Ryan White providers and CPs and will synchronize our transition process with the State and DPH.

Enrollment Update: Prior to the start of the new HWLA program on July 1, 2011, there were 62,052 active HWLA members. The overall rate of enrollment into HWLA continues at quadruple the previous rate due to the success of the Operation Full Enrollment campaign. DHS will extend Operation Full Enrollment through the end of the year. DHS is confident the operations put in place during that time frame will continue, regardless of whether there is an official campaign. From July 1st through November 6th of this year over 100,000 patient contacts were made, and over 37,000 patients were enrolled by DHS, DMH and CPs.

Programmatic Update: DHS has regular communication with stakeholders to troubleshoot issues, averaging 50-60 participants during our weekly calls and working closely with CPs to improve processes such as claims and enrollment. The website (www.ladhs.org/hwla) continues to be updated with content for providers and staff as well as for patients and the general public. The success of the program outreach can also be measured by the number of visits to the site, which increased from a few hundred earlier in the year to over 9,000 last month.

ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES (SPDs) IN DHS

In the first five months of SPD enrollment (June 1 to November 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers was 15,969 (53% of our enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have previously received care from DHS, but the majority of the SPD patients enrolled in DHS are new. In order to meet the service needs for the SPD patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes.

IMPROVING PRIMARY CARE AND SPECIALIST ACCESS

As we transform our system to meet health care reform requirements and enrollment of SPD patients, improving specialty care access is critical. For the last 6 months, DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS Emergency Rooms, who did not have a primary care provider. Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by the primary care provider and specialist. In collaboration with our Community Partners, who provided DHS with over 23,000 appointment slots, DHS identified and linked approximately 22,000 patients to Community Partners. We are working with the CPs to determine the final number of patients that actually scheduled and kept primary care appointments with the CPs for the first quarter.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

DHS will provide the next update on DSRIP by December 16, 2011.

NEXT STEPS

The next status report to your Board is targeted for December 16, 2011. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:sr

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Department of Mental Health
Department of Public Health

Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

December 14, 2011

TO: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON HEALTHY WAY LOS ANGELES ENROLLMENT AND THE 1115 MEDICAID WAIVER**

On June 14, 2011, your Board instructed the Chief Executive Officer and the Director of Health Services to report back in 90 days and monthly thereafter with data regarding enrollment trends in the Healthy Way Los Angeles (HWLA) Matched and Unmatched programs. On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health (DMH) and Public Health (DPH) to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). This report is in response to both motions.

HEALTHY WAY LOS ANGELES – LOW INCOME HEALTH PROGRAM (LIHP)

Network Update: On June 14, 2011, your Board approved the new HWLA agreements with Community Partners (CPs) covering HWLA Matched and Unmatched Services. This new agreement replaced the previous Public -Private Partnership Program, HWLA and SB 474 contracts. On September 20, 2011, your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White Care Act program clients to HWLA. We received signed contract amendments from all, but a few Ryan White providers and CPs and will synchronize our transition process with the State and DPH.

HWLA Enrollment Status and Trends: HWLA is part of the California Health Care Coverage Initiative that seeks to expand health care coverage for eligible individuals in Los Angeles County. The initial HWLA program began in September 2007. The HWLA program with new programmatic and enrollment requirements commenced on July 1, 2011. As of November 30, 2011, over 100,000 individuals have been enrolled in the HWLA program.

One of DHS' immediate goals is to enroll eligible patients within DHS operated facilities, CP clinics, and DMH-operated clinics into the HWLA Matched Program. In order to accomplish this goal, the newly formed DHS Ambulatory Care Network (ACN) team spearheaded a campaign entitled Operation Full Enrollment. At the end of November, this intensive "in-reach" campaign, which included phone calls and patient outreach through the use of volunteers officially ended.

The campaign's achievements include almost 150,000 telephone or direct patient contacts made by DHS staff. During this campaign, El Monte, Mid-Valley and Humphrey Comprehensive Health Centers, and High Desert and MLK Multi-Ambulatory Care Centers exceeded 1,000 new HWLA enrollees. Hudson Comprehensive Health Center, Harbor-UCLA Medical Center and Olive View Medical Center exceeded 2,000 new enrollments, and LAC+USC Medical Center exceeded 4,000 new enrollments. Rancho Los Amigos National Rehabilitation Center exceeded 100% of its target enrollment population. Total new enrollment in DHS has exceeded 22,800 (See Attachment 1).

Since July 1, 2011, CPs have enrolled over 21,400 patients and DMH has enrolled over 1,400 patients. More than 45,000 new HWLA patients have been enrolled over the past five months. This is more than a 70 percent increase from the total number of enrolled HWLA patients prior to July 1, 2011. Although Operation Full Enrollment has ended, DHS, the CPs, and DMH continue to enroll all eligible HWLA patients.

Community Partner Update: Feedback from CPs and DHS staff continues to be incorporated. The weekly HWLA support call for stakeholders continues to average 50-60 participants with timely answers and report backs to the group. The website (www.ladhs.org/hwla) continues to be updated with content for providers and staff as well as for patients and the general public. DHS has recently made two modifications to the enrollment and billing process to make it easier for CPs to enroll and cover patients in a manner that is more convenient and timely.

DHS continues to seek feedback from stakeholders through a variety of community clinic and social service meetings. In the past few months, a number of operational issues have been identified and significant progress has been

achieved. As a result of the strain experienced by the CPs from a combination of the managed care Medi-Cal Seniors and Persons with Disability transition and HWLA programmatic requirements, we plan to bring to the Board recommended contract amendments to help ease the process.

Future Steps: Over the past three months, DHS, along with DMH and CP representatives have been working extensively with the Department of Public Social Services on a how to ease the enrollment process for both staff and patients. Representatives have been detailing the content and process flow for LEADER and Your Benefits Now . This is viewed as an important technical improvement from the current enrollment platform. A number of the challenges that have been identified in the existing enrollment process are being addressed in these detailed requirements meetings. The estimated implementation date for the new system is May 2012.

ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES (SPDs)

In the first six months of SPD enrollment (June 1 to December 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers was over 18,000 (>60% of our enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have previously received care from DHS, but the majority of the SPD patients enrolled in DHS are new. In order to meet the service needs for the SPD patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes. We are reviewing the financial impact of the SPD patients and will work with L.A. Care to determine whether or not we should adjust the enrollment target.

IMPROVING PRIMARY CARE LINKAGE AND SPECIALIST ACCESS

As we transform our system to meet health care reform requirements, improving primary care linkage and specialty care access is critical. For the last six months, DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS emergency rooms, who did not have a primary care provider. Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by the primary care provider and specialist. In collaboration with our CPs, DHS identified and linked approximately 22,000 patients to CPs. We are working with the CPs to determine the final number of patients that actually scheduled and kept primary care appointments with the CPs for the first quarter. Given the strain experienced by the CPs, we will temporary delay the assignment of the remaining specialty service patients to CPs.

This will enable both DHS and CPs time to review how we can improve this process to link patients back to primary care providers.

DHS, CPs, and L.A. Care are also working together to modify a telehealth technology (eConsult) that enables primary care providers and specialists to exchange consultations in a "store and forward" manner. This is a proven intervention that has worked well in San Francisco and Los Angeles, as well as other safety net and integrated delivery systems.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

DHS will report to the State and CMS progress toward achieving the milestones for Demonstration Year (DY) 7 by March 31, 2012. Attached is a summary of relevant updates for each milestone.

NEXT STEPS

As directed by your Board, DHS will continue to provide monthly reports regarding HWLA enrollment trends and the status of implementing the 1115 Waiver. The target date for the next status report is January 13, 2012. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:sr

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Mental Health

ATTACHMENT 1

Healthy Way LA
LOS ANGELES COUNTY

OPERATION FULL ENROLLMENT
Data Report - DHS Enrolling Sites
Week Ending December 11, 2011

	Enrollment																							Total Enrollment
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17	Week 18	Week 19	Week 20	Week 21	Week 22	Week 23	
DHS Enrolling Sites	7/1-7/11	7/12-7/18	7/19-7/24	7/25 - 7/31	8/1 - 8/7	8/8 - 8/14	8/15 - 8/21	8/22 - 8/28	8/29 - 9/4	9/5 - 9/11	9/12 - 9/18	9/19 - 9/25	9/26 - 10/2	10/3 - 10/9	10/10 - 10/16	10/17 - 10/23	10/24 - 10/30	10/31 - 11/6	11/7 - 11/13	11/14 - 11/20	11/21 - 11/28	11/29 - 12/4	12/5 - 12/11	
BELLFLOWER HC	37	12	26	27	10	5	6	3	15	4	7	7	24	0	3	28	8	9	4	20	0	0	0	255
EDWARD R. ROYBAL CHC	10	15	82	41	76	16	13	24	14	28	33	29	46	41	34	40	10	71	38	31	9	39	29	769
EL MONTE CHC	61	123	46	124	63	127	124	110	17	3	156	124	133	90	67	97	37	55	93	129	27	114	63	1,983
H. CLAUDE HUDSON CHC	54	180	63	72	70	99	128	115	95	44	91	109	71	109	43	140	63	85	103	88	43	97	128	2,090
H.H. HUMPHREY & DOLLARHIDE**	54	62	93	149	14	5	78	35	89	26	122	96	117	57	31	46	67	67	82	38	37	35	26	1,426
HARBOR-UCLA MED CTR	26	93	152	89	122	123	163	168	135	155	187	173	92	111	94	158	122	137	77	83	56	53	76	2,645
HIGH DESERT AREA***	1	48	26	59	73	83	44	98	65	41	71	71	73	121	84	86	56	55	53	42	46	90	54	1,440
LA PUENTE HC	28	5	5	25	9	19	4	12	4		24	6	9	11	3	3	9	8	10	12	3	9	6	224
LAC+USC MED CTR	135	123	325	173	120	257	205	201	233	182	196	107	255	247	165	254	260	260	169	191	138	200	108	4,504
LONG BEACH CHC	35	53	34	35	32	6	7	46	24	4	9	57	26	9	3	43	53	49	18	31	18	53	28	673
MID-VALLEY CHC & GLENDALE†	1	39	39	65	48	39	45	38	48	52	69	46	57	57	38	77	68	79	59	41	22	49	41	1,117
MLK MACC	16	23	8	122	47	107	172	94	174	98	146	121	71	64	106	91	43	40	95	14	71	107	60	1,890
OLIVE VIEW-UCLA MED CTR	22	34	43	38	114	145	144	217	198	125	211	111	149	157	62	85	208	99	96	138	187	86	88	2,757
RANCHO LOS AMIGOS NRC	11	19	11	26	9	5	11	23	17	25	15	28	33	22	12	25	26	34	31	44	19	31	15	492
SAN FERNANDO HC	9	24	31	18	9	38	14	0	1	51	10	33	17	17	22	14	26	27	20	8	18	9	8	424
WILMINGTON HC	0	0	0	0	9	10	7	11	0		0	0	4	0	0	0	0	0	0	0	0	0	0	41
UNKNOWN DHS SITE	0	0	0	0	0	0	0	0	0	0	0	0	26	0	0	0	0	0	1	0	18	14	91	150
TOTAL DHS	**500**	**853**	**984**	**1,063**	**825**	**1,084**	**1,165**	**1,195**	**1,129**	**838**	**1,347**	**1,118**	**1,203**	**1,113**	**767**	**1,187**	**1,056**	**1,075**	**949**	**910**	**712**	**986**	**821**	**22,880**

* Target is 75% of total patients eligible for HWLA.

** Hubert H. Humphrey CHC is doing the scanning for Dollarhide HC. Their inreach and enrollment numbers are combined.

*** High Desert area includes High Desert MACC, South AV, Littlerock, Lake Los Angeles, and AV HC. High Desert MACC is doing the scanning for all facilities in the region, therefore all numbers are combined.

† Mid-Valley CHC is doing the scanning for Glendale HC. Their inreach and enrollment numbers are combined.

DSRIP DY 7 Milestones		
Project	**Milestone**	**December 2011 update**
Category I		
Implement and Utilize Disease Management Registry Functionality	Disease management registry functionality is available in at least one clinic in each of at least 8 DHS facilities.	DHS signed a contract with the new Disease Management Registry (DMR) vendor, i2i, on October 21, 2011. Implementation will begin in January 2012 and continue throughout the Winter and Spring of 2012. DHS will report compliance with the DY7 milestone based on usage of the previous DMR.
	At least 55% of patients with diabetes, heart failure or asthma seen in the clinics with registry access are entered into the registry.	
Enhance Urgent Medical Advice	Expand access to NAL by 10% over baseline.	Data on NAL usage rates is being collected and will be trended on a quarterly basis. Current usage is >10% over baseline based on six-month comparison period.
	Increase by 10% over baseline the number of NAL patient contacts who reported intent to go to the ED for non-emergent conditions but were redirected to non-ED resources.	
Enhance Coding and Documentation for Quality Data	Implement HIPAA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions.	All facilities have 5010 upgrades; message testing is still in progress.
	Train staff on the changes in work flow.	DHS employees require only minimal training on workflow changes related to implementation of HIPAA 5010. DHS is currently in the process of developing a plan to train staff on changes in workflow required for ICD-10 conversion.
Enhance Performance Improvement and Reporting Capacity	Participate in CHART or other statewide, public hospital or national clinical database for standardized data sharing.	As of December 2011, Harbor UCLA, LAC+USC, and Olive View Medical Center continue to report data to CHART (California Hospital Assessment and Reporting Taskforce) as well as to the University Health Consortium (UHC). Rancho reports Functional Independence Measures (FIM) to the Uniform Data System for Medical Rehabilitation; it is in the process of initiating participating with UHC as well.
	Share quality dashboard or scorecard (including patient satisfaction measures) with organizational leadership on a regular basis; post on DHS public website.	Performance measures are continually reported to senior leadership. DHS public website continues to report quality and patient satisfaction data.
Category II		
Expand Medical Home	Ensure at least 20 primary care providers deliver care using the medical home model.	128 medical home teams (providers and associated nursing/clerical support staff) have been designated and formed. Teams have began working together, practicing according to the medical home model. By the end of December 2011, 45 teams have undergone simulation training on the medical home model of team-based care delivery.
	Assign at least 10,000 patients to provider-led medical home teams.	DHS has empaneled 240,000 patients into medical homes in DHS operated clinics.
Expand Chronic Care Management Model	Determine baseline percentage of patients with diabetes, heart failure or asthma with at least one recorded self-management goal.	DHS will await implementation of I2i before collecting and reporting baseline data.
	Implement a comprehensive risk-reduction program for patients with diabetes mellitus that includes glycemic, blood pressure and lipid control in primary care. Target patients include those with Diabetes related inpatient admissions and those with high risk score (HgA1c + LDL + BP).	A comprehensive risk-reduction program has been implemented among high risk patients with diabetes. DHS will continue to monitor the effects of this program.
	Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types.	Baseline established in June 2011. Individual clinics are increasing their use of "nontraditional" visits in order to more effectively and efficiently serve patients.
	Determine baseline: Blood pressure control among patients with completed stroke who are empaneled at any primary care medical home with registry access.	DHS will await implementation of I2i before collecting and reporting baseline data.
Integrate Physical and Behavioral Health Care	Co-locate mental health services with primary care in 4 LAC DHS directly operated or contract facilities.	Five co-location sites are currently operating (El Monte, High Desert, Humphrey, Long Beach, Roybal). Staff recruiting efforts continue at MLK & Mid-Valley. Hudson will be added as a co-location site once adequate space has been identified.
	Track referrals from primary care providers to on-site mental health professionals to be used at the co-location sites.	Tracking mechanism is in place.
	Use joint consultations and treatment planning at co-location sites, and coordinate resources to improve patient education, support, and compliance with the medication regimen.	A draft joint consultation policy has been developed; it will be piloted and then further refined in Winter 2012.
	Integrate depression screening to 15% of enrolled patients with diabetes assigned to co-location sites.	Baseline data will be collected in January 2012. If needed, providers will be further educated regarding indications and methods for screening patients with depression.
	Ensure at least 70% of initial behavioral health visit appointment waiting times among patients enrolled in DHS medical homes who meet medical necessity criteria are less than 30 business days.	DHS is working on processes to efficiently collect and report data. Initial data will be available in Winter 2012. Co-located DMH staff are adjusting referral flows in response to high referral volumes at specific co-located clinics in order to achieve mandated access standards for managed care populations.

DSRIP DY 7 Milestones		
Project	**Milestone**	**December 2011 update**
Category III		
Patient/Care Giver Experience	Undertake the necessary planning, redesign, translation, training, and contract negotiations in order to implement CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) in DY8	DHS is preparing for contract negotiations with the CG-CAHPS survey vendor.
Care Coordination	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	The Office of Planning has pulled preliminary data for DY7 metrics. It is working with IT to ensure DHS has the infrastructure needed to report metrics that begin in DY8.
	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
Preventive Health	Report the following: Numerator: All female patients age 50 - 74 years who had a mammogram to screen for breast cancer within 24 months Denominator: Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 50 and older who received an influenza immunization during the flu season (September through February) Denominator: Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
At Risk Populations	Report the following: Numerator: All patients age 18 - 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 18 - 75 years with diabetes whose most recent hemoglobin A1c level is in control (<9%) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	

DSRIP DY 7 Milestones		
Project	**Milestone**	**December 2011 update**
Category IV		
Improve Severe Sepsis Detection and Management	Form DHS wide Sepsis Collaborative	Completed
	Revise CME approved curriculum used to train ED nurses and physicians in the detection and treatment of severe sepsis and septic shock patients	Completed
	Train 30% of ED nurses and physicians on severe sepsis and septic shock detection and treatment	Completed and ongoing
	Create Sepsis Resuscitation Order Set that includes the resuscitation bundle elements.	Completed
	Allocate resources for expert support	Completed
	Allocate resources for data collection methodology development	Completed
	Allocate resources for data collection	Completed
	Report at least 6 months of data collection on Sepsis Resuscitation Bundle to Safety Net Institute (SNI) for purposes of establishing the baseline and setting benchmarks.	Baseline data collected and validated; ready for reporting to SNI
	Report the Sepsis Resuscitation Bundle results to the State.	Data collection in process; to be reported to the State at end of DY7 reporting period
Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention	Develop a mandatory curriculum/ used to train and orient physicians in the insertion of central lines	Completed
	Provide ongoing education to ICU staff on care of central lines	Completed and ongoing
	Allocate resources to provide expert support	Completed
	Allocate resources to develop data collection methodology	Completed
	Allocate resources to collect data on implementation of central line bundle	Completed
	Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks.	Completed
	Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks.	Baseline data collected and validated; ready for reporting to SNI
	Report CLIP results to the State.	Data from first six months of DY7 to be reported to the State in March 2012
Reduce Complications of Surgical Procedures	Assess understanding of and compliance with 6 SCIP Core measures for identified procedures using UHC Core Measure Data set	Completed
	Address provider knowledge deficits using a variety of strategies e.g., team training	Completed and ongoing
	Develop dashboard to compare compliance with SCIP Core measures using UHC Core Measure Data for CDPH targeted procedures	Completed
	Report at least 6 months of data collection on SSI to SNI for purposes of establishing the baseline and setting benchmarks.	Baseline data collected and validated; ready for reporting to SNI
	Report results to the State.	Data from first six months of DY7 to be reported to the State in March 2012

DSRIP DY 7 Milestones		
Project	**Milestone**	**December 2011 update**
Venous Thromboembolism (VTE) Prevention and Treatment	Form DHS VTE prevention collaborative	Completed
	Set general goals and a timeline for construction of and implementation of VTE protocol	Completed
	Allocate resources for expert support	Completed
	Allocate resources to develop VTE data collection methodology	Completed
	Allocate resources to collect data on VTE measures	Completed
	Report at least 6 months of data collection on the VTE management process measures to SNI for purposes of establishing the baseline and setting benchmarks.	Baseline data collected and validated; ready for reporting to SNI
	Report the 5 VTE process measures data to the State.	Data collection in process; to be reported to the State at end of DY7 reporting period